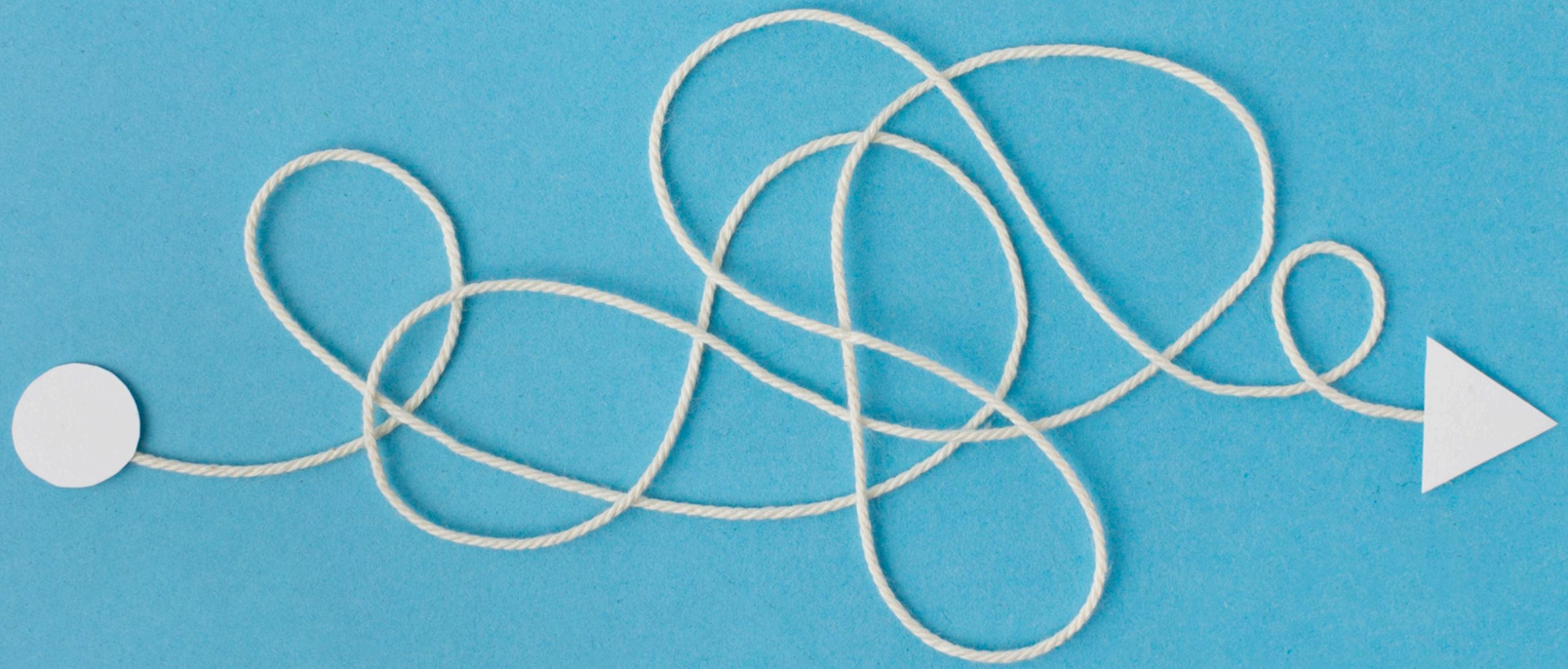
9 Eyecare Billing Solutions from the Front Desk to the Back Office



Intro

Hiccups in your practice's billing process can have a ripple effect all the way to your bottom line. Whether it's from confused patients not understanding their benefits and payment responsibility to high denial rates to poorly managed accounts receivable - these can all negatively affect your practice's cashflow.

In this ebook, we will share 9 of the most common challenges we see throughout an eyecare practice's billing workflow and suggest solutions to help overcome these challenges and get back on track.

1. Lack of information gathered at scheduling
2. Incomplete insurance verification
3. Unclear patient check-out
4. Rocky patient transition to exam
5. Incorrect determination of medical condition
6. Incorrect documentation of medical exam
7. Inaccurate credentialing
8. Medical claim rejections
9. Reimbursements not verified

Common Problems at the Front Desk

Lack of Information Gathered at Scheduling

Communication when an appointment is scheduled is critical for both the patient and your team. Important pieces that need to be clearly defined, but that we often see as overlooked at the time an appointment is scheduled include:

- **Collection and documentation of all patient demographics**
- **Collection and documentation of medical insurance policies**
- **Conversation of the patient's benefits and payment responsibilities**

Solution

Lack of Information Gathered at Scheduling

- Collection and documentation of all patient demographics is often times incomplete and inconsistent
- Collection and documentation of medical insurance policies is often overlooked and missing
- Conversation of the patient's benefits and payment responsibilities is often skipped at this step setting unclear expectations and confusion

- **Create a process to collect and document all patient demographic information including: patient name, DOB, medical and vision carrier plan, guarantor of insurance, and guarantor DOB**
- **Require the collection of medical insurance policies when the appointment is scheduled**
- **Create a script to ensure the conversation of patient benefits and payment responsibilities is detailed when the appointment is scheduled**

Incomplete Insurance Verification

Utilizing medical insurance benefits in an eyecare practice often goes overlooked. Setting you and your team up for success when it comes to the medical model in eyecare starts with the insurance verification process. Most often, we see these roadblocks when it comes to medical insurance:

- **No dedicated process for medical insurance verification**
- **Medical insurance isn’t verified prior to a patient visit**
- **If a patient has medical insurance benefits, they are often aren’t being used properly**

Solution

Incomplete Insurance Verification

- No dedicated process for medical insurance verification
- Medical insurance isn’t verified prior to a patient visit
- If a patient has medical insurance benefits, they are often aren’t being used properly

- **Establish a documented process where medical insurance verification is verified prior to every patient being seen**
- **All information needs to be placed on a routing slip sheet/face sheet, or within notes in the EHR including:**
  - **Co-pay and deductible for medical insurance**
  - **Co-pay, materials benefit, and details of the vision plan**

Unclear Patient Check-out

The check-out process is a very critical component of a healthy accounts receivable process. According to one study*, patients are 50% less likely to pay their bill once they leave. There are two main reasons why the check-out process can lead to less revenue for the services you provided that day.

- **Patient responsibilities are not consistently collected (required by law)**
- **Staff are determining the co-pay to collect at check-out: either vision or medical without being clear on the doctor's work in the exam lane**

*https://www.financesysteminc.com/10-patient-pay-statistics-you-should-know/

Solution

Unclear Patient Check-out

- Patient responsibilities are not consistently collected (required by law)
- Staff are determining the co-pay to collect at check-out: either vision or medical without being clear on the doctor’s work in the exam lane

- **Define a script and process for ensuring payment collection at the time of check-out, including all co-pays and unmet deductibles**
- **Patients are scheduled according to defined follow-up based on clinical protocols**

Common Problems in the Exam Lane

Rocky Patient Transition to Exam

Ensuring that patient communication from all of your staff throughout the office is consistent and accurate makes the entire patient visit run more smoothly. Inconsistent messaging can cause confusion and analysis paralysis for a patient. These are a few areas that we most often see miscommunication during the visit:

- **Lack of patient education on the medical nature of pre-testing during the work up**
- **Staff is developing and documenting the chief complaint for the doctor**
- **Staff reinforces the patient's chief complaint rather than allowing the doctor to determine if medical necessity exists**

Solution

Rocky Patient Transition to Exam

- Lack of patient education on the medical nature of pre-testing during the work up
- Staff is developing and documenting the chief complaint for the doctor
- Staff reinforces the patient's chief complaint rather than allowing the doctor to determine if medical necessity exists

- **Use the pre-test time as the opportunity to discuss the medical purpose for each test**
- **Don't allow staff to record anything in the chief complaint area of the exam form - this is only to be done by the OD**
- **Staff should advise patients before the doctor comes in that some complaints may be of medical nature and beyond the scope of a routine exam**

Incorrect Determination of Medical Condition

Identifying a patient's medical condition at the right time and by the right person is imperitive for successful medical filing. Here are some of the common pitfalls of incorrectly determining a patient's condition.

- **Patient is not considered for medical conditions first by the doctor**
- **Staff is developing the chief complaint based on casual conversation with patient**
- **Doctor allows patient to self select care based on their expectations of co-payment**

Solution

Incorrect Determination of Medical Condition

- Patient is not considered for medical conditions first by the doctor
- Staff is developing the chief complaint based on casual conversation with patient
- Doctor allows patient to self select care based on their expectations of co-payment

- **Doctor determines the chief complaint based on medical complaints if present, do not ignore them**
- **Inform patient if there are one or more medical issues**
- **Give the patient the option to proceed with the medical exam or stay within the boundaries of the routine exam (most will want attention to any problems that day)**

Incorrect Documentation of Medical Exam

Correct documentation plays a role both in the success of your claim denial rate and in ensuring compliance for your practice. The most common documentation errors we see with medical exams include:

- **Missing information leading to incomplete documentation of medical exam**
- **Chief complaint not supported by medical record or necessity**
- **Missing interpretation and report for appropriate procedures**
- **Documentation in medical record does not match what was billed to the carrier**
- **Wrong codes utilized (E&M level/exam code) based on care provided**

Solution

Incorrect Documentation of Medical Exam

- Missing information leading to incomplete documentation of medical exam
- Chief complaint not supported by medical record or necessity
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- **Both doctor and staff are responsible for documenting all elements of the exam**
- **Services provided by the clinician must meet:**
  - **Medical necessity**
  - **Medicare coverage criteria**
  - **Rendered and documented in patient's record**
  - **CPT code criteria**

Common Problems in the Back Office

Inaccurate Credentialing

Credentialing is a piece of the puzzle that sometimes goes overlooked or is mismanaged due to a lack of time or expertise. A few of the biggest credentialing errors we see are:

- **Practice is set up as individual**
- **Doctor providing care is not rendering provider on claim**

Solution

Incorrect Documentation of Medical Exam

- Practice is set up as individual
- Doctor providing care is not rendering provider on claim

- **Perform an overall review of credentialing for the practice and ensure the practice is set up as a group**
- **Make sure doctors are credentialed and not providing care under another’s providership**
- **All information should be kept up-to-date in the applicable online sytems**

Medical Claim Rejections

Claim rejections and denials are going to happen in every practice, but the goal is to keep them as low as possible to reduce the admin workload of managing denials and to keep your cash flow high. We most often see practices struggle with rejections for the following reasons:

- **Claims are not being filed daily**
- **Improper ordering of diagnosis/procedures**
- **Improper rendering of NPI**
- **Missing information**
- **Submitting refractive diagnosis to Medicare**

Solution

Medical Claim Rejections

- Claims are not being filed daily
- Improper ordering of diagnosis/procedures
- Improper rendering of NPI
- Missing information
- Submitting refractive diagnosis to Medicare

Claims should be filed daily

Prior to submitting a claim, review:

- **Patient demographics**
- **Insurance information**
- **Physician information**
- **Coding**

Reimbursements Not Verified

Managing reimbursements and putting in place the right process so that your revenue cycle has consistent checks and balances helps keep your account receivables in check and ensures that you are getting paid for the care and services you deliver. Common reimbursement verification roadblocks include:

- **Improper fee structure where reimbursements are less than insurance allowables**
- **Balances written off instead of collecting from patient or refiling to proper insurance**
- **Hiding accounts receivable errors in write-offs, rather than working to correct issues**
- **No process for handling denied claims**

Solution

Reimbursements Not Verified

- Improper fee structure where reimbursements are less than insurance allowables
- Balances written off instead of collecting from patient or refiling to proper insurance
- Hiding accounts receivable errors in write-offs, rather than working to correct issues
- No process for handling denied claims

- **Fees should be reviewed annually and adjusted if necessary**
- **Payments should be posted as they are received and statements sent to patients if applicable**
- **Establish process for denial management**
- **Implement a monthly accounts receivable review process**

Claims Processing Responsibility Chart

FRONT DESK

1

SCHEDULING

Get patient insurance info/ID # and input demographics in PM system

2

REQUIRED DEMOGRAPHICS

Patient name, DOB, relation to insured, insured name and DOB, insurance name, Group #, ID #

3

VERIFY DETAILS

Verify medical & vision plan benefits to determine co-pay, deductible, & procedures coverage

4

AT CHECK-IN

Update patient info, scan cards, confirm details entered in PM system, verify mailing address

OD/ TECH

5

DETERMINE CHIEF COMPLAINT

OD determines vision vs. medical examination

6

DURING EXAM

OD enters CPT, DX codes and modifiers prioritized and linked appropriately for patient invoicing

CHECK OUT

7

CREATE CLAIM

Create new claim and confirm all fields are complete and correct prior to filing

8

CREATE INVOICE

Create bill with CPT, DX, & modifiers in place and specify insurance for claim. Collect patient co-pay & deductible

BILLER

9

SUBMIT CLAIM

Batch claim and upload to the clearinghouse

10

REVIEW CLAIMS

Review uploaded batches vs. your PM system for accuracy and verify claims processed through the clearinghouse & correct rejections

11

INTERPRET ERA

If denied, correct claim as required in payer appeal process

Improve Your Billing Process in One Step

OMS works with practices everyday to help them get paid for the care they provide by identifying billing roadblocks with solutions that lead to stronger revenue performance.

Schedule a consultation with us today to take the next step with your practice.

Book a Consultation

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